State of California—Health and Human Services Agency

Department of Health Services

California Department of Health Services

ARNOLD SCHWARZENEGGER
Governor

Dear Provider:

The Department of Health Services (DHS) requires that a change of pay-to address or mailing address on the provider's master file for an institutional provider must be submitted by a notarized request from the legal owner, as designated by the facility's license. No other requests for a change in the pay-to address or mailing address will be honored except for a court order designating a court-appointed receiver.

☐ I hereby request that the pay-to address of:

Facility name

Medi-Cal provider number	Federal Employer Identification Number (FEIN)

Be changed from (old address):

(Number, street)	City	State	ZIP code

To (new address):

(Number, street)	City	State	ZIP code

☐ I hereby request that the mailing address of

Facility name

Medi-Cal provider number	Federal Employer Identification Number (FEIN)

Be changed from (old address):

(Number, street)	City	State	ZIP code

To (new address):

(Number, street)	City	State	ZIP code

Facility name	Medi-Cal provider number

I hereby unconditionally release and forever discharge the State of California and each and all of its agents, officers, and employees from any and all claims, damages, costs, expenses, and right to compensation whatsoever, which I now have or may hereafter accrue on account of, or in any way as a result of this notice of change of address.

I (we), the undersigned, have read this release and fully understand it.

Dated this _____ day of _____ (month), _____ (year)

Corporation name	Federal Employer Identification Number (FEIN)
Authorized signature	Title

State of _____, County of _____

On the _____ day of _____, 20 _____ before me,

_____ a Notary Public, personally

appeared _____ known to me to be the person

whose name is subscribed to the within instrument and acknowledged that (s)he executed the same.

_____
(Notary Public in and for said County and State)

This form must be signed, notarized, and returned to:

California Department of Health Services
PSD/Provider Enrollment Branch/Facilities
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Note: Any change of "Service" address for Long Term Care or Inpatient/Outpatient providers must be processed by the local Licensing and Certification Division of the Department of Health Services. If you cannot contact the local branch, call Licensing and Certification headquarters in Sacramento at (916) 552-8700 for more information.